No. 86-1764

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In the Supreme Court of the United States

OCTOBER TERM, 1987

BETHESDA HOSPITAL ASSOCIATION AND
THE DEACONESS HOSPITAL OF CINCINNATI, OHIO,
PETITIONERS,

v.

OTIS R. BOWEN, M.D., SECRETARY
OF HEALTH AND HUMAN SERVICES,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

REPLY BRIEF FOR THE PETITIONERS

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ARGUMENT

I. INTRODUCTION

The Secretary concedes that *Athens Community Hospital, Inc. v. Schweiker*, 743 F.2d 1 (D.C. Cir. 1984) ("Athen II"), *modifying* 686 F.2d 989 (D.C. Cir. 1982) ("Athen I"), was wrong in holding that 42 U.S.C. § 1395oo(d) (1982) controls the Board's jurisdiction, and he agrees that section 1395oo(a) (1982) is the governing statutory provision. Resp. Br. at 11. Nevertheless, the Secretary seizes upon fragments of the *Athens* analyses and attempts to apply them in the context of section 1395oo(a). Among the fragments of the *Athens* reasoning heavily relied upon by the Secretary are the notions that

the filing of the cost report is an adversary proceeding, that the intermediary resolves disputes in auditing the cost report, and that the PRRB is an appellate body. These are fundamental mischaracterizations of the administrative process, as we will demonstrate below.

A second concession by the Secretary completely undermines his interpretation of the statute and the alleged practical justifications for that interpretation. The Secretary acknowledges that a provider may raise a claim before an intermediary simply by "noting its disagreement with the policy or regulation governing the reimbursement issue." Resp. Br. at n.8. In such a circumstance, the provider fills out its cost report in accordance with the regulations and then attaches to the completed cost report a cover letter indicating it wishes to contest a particular regulation. The intermediary does not write an audit adjustment, and its audit of the cost report is exactly the same as for a self-disallowing hospital. The provider need not even provide the alternative amount of reimbursement it would receive. *See Athens II*, 743 F.2d at 5, 8 n.12.

Nonetheless, the Secretary finds this cover note sufficient for a provider to preserve its appeal rights. This process serves *none* of the exhaustion considerations put forth by the Secretary to justify his interpretations, and functionally is no different from the situation of the Hospitals here. If the Board accepts jurisdiction over providers based on the contents of a cover note, without an adjustment by the intermediary, there is no justifiable reason why the Board cannot assert jurisdiction over providers that self-disallow costs by complying with a regulation without the benefit of a cover note.

II. THE NATURE OF THE COST REPORTING PROCESS DOES NOT SUPPORT THE SECRETARY'S POSITION

The Secretary contends that the Hospitals should not be heard on their claim for self-disallowed costs where they have treated the malpractice premium costs in their cost

reports in a manner consistent with his regulation. The common base for his arguments is that the self-disallowance operates to avoid an implied or unstated adversary process in the cost reporting process in which the intermediary is both adversary and tribunal. This argument is woven throughout the Secretary's Brief more by suggestion, implication and legerdemain than by direct assertion. Not only is it the foundation for all of the Secretary's arguments focusing on the cost report audit process, it also is the *sine qua non* for his argument that requiring the PRRB to entertain appeals involving self-disallowed costs improperly forces the PRRB to act as the trial forum and denies it the appellate function. In fashioning these arguments the Secretary creates a house of cards.

A. Filing A Cost Report Is Not An Adversarial Process

The fundamental weakness in the Secretary's entire argument is that it rests upon a distorted characterization of the cost reporting process. The Secretary claims that when his contract agent, the intermediary, receives a cost report submitted by a provider and then audits that cost report to assure that only those costs permitted under the Secretary's regulations, instructions and policies are reimbursed, the intermediary is *not* performing an audit function as required by the statute, regulations, manual instructions and intermediary contract. Rather, the Secretary claims, the intermediary is acting both as adversary and as a tribunal in an adversary proceeding. This position not only flies in the face of common sense, it is contrary to the regulatory scheme and the contract under which the intermediary operates.

First, it should be noted that the intermediary's job in auditing a provider's cost report is to verify and audit documentation of the costs included in the cost report as

to whether such costs were actually incurred in providing covered services, and the nature and amount of such costs. In addition, the intermediary determines whether the provider has properly classified such costs as to the services provided and then properly apportioned those costs between Medicare and non-Medicare functions.[1] Pursuant to their contracts, the intermediaries perform these tasks through the application of the Secretary's regulations, rulings, manual instructions and policies. When a cost is not addressed by a specific written directive such as a manual instruction, the intermediaries are instructed to use generally accepted accounting principles to account for the cost. (Provider Reimbursement Manual, Forward).

If either the amount of actual cost has been incorrectly submitted or the calculation of the Medicare program's share of the cost is not in accordance with regulations (the substantive issue in this case), then the intermediary is required to make correcting adjustments in the cost report. Otherwise, the intermediary takes no action other than to pay Medicare's share as calculated under the regulation.

Except with respect to costs that are not addressed by written pronouncements from the Secretary or by generally accepted accounting principles, or with respect to the characterization of costs that may fall into more than one category or classification, the intermediary has *no* discretion in how costs in a cost report are to be treated. This case does *not* involve the cost report treatment of any costs with respect to which the intermediary has any discretion. It involves the apportionment of malpractice premium costs which is definitively controlled by a regulatory formula which the intermediary is absolutely bound to apply.

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[1] Since the Hospitals' malpractice premium costs were included in the cost report, the intermediary did verify the nature, amount, classification and apportionment of these costs during its audit for purposes of payment under the discredited 1979 Malpractice Rule.

Simply put, the intermediary's hands are tied in that it can only apply the regulations and instructions to costs that are in the cost report. Where an instruction or a regulation (such as the Malpractice Rule) results in what a provider perceives as underpayment with respect to Medicare's share, contrary to the Secretary's suggestion (Resp. Br. at 10-11) there is no dispute with the intermediary. The dispute is with the Secretary and his policies as implemented by regulation or instruction. In that context, to say, as the Secretary does, that no dispute can arise unless the provider demands from the intermediary what the Secretary has forbidden the intermediary to give, creates the false illusion that somehow the intermediary could give relief in the case of disputes over reimbursement amounts that are mandated by regulation.

In contrast to the Secretary's suggestion (Resp. Br. at n. 10), the intermediary's audit of the provider's cost report pursuant to regulations is not an adjudication; it is nothing more than an audit to assure compliance with the applicable regulations. The intermediary is not an adversary and does not sit as an adjudicatory body any more than are auditors doing a reconciliation for the final payment under any government cost contract.

The notion that the intermediary is an adversary or sits as an adjudicatory body when it audits a provider's cost report is also inconsistent with statutorily authorized functions (42 U.S.C. § 1395h(a) (1982)) which the Secretary has included in the intermediary contracts. Under these provisions, the intermediaries are charged not only with auditing provider cost reports and making payments but also with acting as consultants to the providers in assisting them to establish financial reporting systems that will facilitate the reimbursement process, and acting as a communications center with regard to communications to and

from the agency. This statutory role of the intermediary as consultant and facilitator is inconsistent with the notion that the intermediary is an adversary or adjudicator during the audit process.

The intermediaries' own conduct makes it clear that they do not perceive themselves as having the function of a tribunal in the audit and payment process. Rather, the intermediaries behave solely as contract agents of the Secretary executing the Secretary's written policies and instructions. For example, in the Malpractice Rule cases which are before this Court on the self-disallowance issue (the instant case and *Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d 1435 (11th Cir. 1987), *cert. pending*, No. 87-380), the Secretary did not seek *certiorari* on the substantive ruling from the Circuits that the 1986 Malpractice Rule could not be applied retroactively. Nonetheless, although that is now the controlling law in the Sixth and Eleventh Circuits, the intermediaries will not pay the providers pursuing follow-up cases on the malpractice issue in the lower courts in those Circuits and at the PRRB under the pre-1979 utilization apportionment method unless they have been specifically directed to do so by the Secretary. That is because the intermediaries perceive their role simply as auditors that calculate costs and payment amounts in accordance with regulations and instructions from the Secretary; they will apply those regulations and instructions faithfully pursuant to their contract so long as the Secretary keeps them in effect, judicial decisions to the contrary notwithstanding. If the intermediaries did in fact act as tribunals, they would have given effect to the controlling law in the Circuit where they are situated without waiting for direction from the Secretary.

Moreover, the Secretary's position that the intermediary sits as a tribunal to examine all relevant evidence and that the PRRB sits as an appellate body is also inconsistent

with the Secretary's own conduct in this case. The Secretary has taken and prevailed on the position that, in the challenge to the validity of the Malpractice Rule in these cases, the courts can only look to the rulemaking record created through the notice and comment process at the time of the rulemaking.[2]

If the Secretary's position is that the courts cannot receive evidence from outside the rulemaking record in a challenge to the regulation, had the intermediary sat as a tribunal in the audit process and permitted the Hospitals to include evidence challenging the Secretary's regulation, the Secretary would not only have disregarded it as being outside the notice and comment process but would have actively prevented it from being considered in a challenge to the regulation. Under such circumstances, for the Secretary to fabricate an adversarial process within the cost report audit process and claim that the Hospitals should now be denied the right to be heard in challenge of his regulation because they did not take the futile step of presenting their claims to the intermediary is nothing more than to ask this Court to endorse a rather mean-spirited illusion.

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[2] The plaintiffs in this case filed with the PRRB expert affidavits attacking the validity of the 1979 Malpractice Rule. These affidavits were part of the administrative record upon which the PRRB granted expedited review. Plaintiffs' Opposition To Defendant's Motion To Strike, pp. 7-9. The plaintiffs attached these affidavits to their complaint in district court. The Secretary moved to strike the affidavits on the ground they were outside the rulemaking record. Memorandum In Support of Defendant's Motion To Strike, pp. 1-2. The motion was granted. Order, Oct. 6, 1983. *See also* Walter O. Boswell Memorial Hospital v. Heckler, 749 F.2d 788, 793-94 (D.C. Cir. 1984).

B. The Administrative History Demonstrates That The Intermediary Does Not Sit As A Tribunal When Auditing Cost Reports.

The Secretary relies upon legislative history associated with the creation of the PRRB as support for his proposition that providers must first challenge disputed regulations in the cost report and thus give the intermediary the opportunity to oppose and adjudicate that claim before it may be taken to the PRRB. After reviewing the carefully selected portions of legislative history, the Secretary states:

> An administrative structure for evaluating reimbursement claims—the intermediary system—was already in place when Congress established the PRRB. Providers necessarily presented all reimbursement claims to their intermediaries, because the intermediaries had sole responsibility for making reimbursement determinations. Nothing in the statutory language or legislative history indicates that Congress intended to displace the preexisting responsibility of intermediaries *to hear and determine* all reimbursement claims in the first instance. The Board was instead created in response to providers' complaints about the unfairness of intermediaries' determinations and their requests for an impartial review panel. It was placed atop the existing administrative structure to serve as an appellate body to referee disputes between providers and their intermediaries. Petitioner's [*sic*] claim . . . is squarely inconsistent with Congress's conception of the Board as an appellate tribunal whose role is to review intermediary determinations.

Resp. Br. at 24 (emphasis added).

The Secretary paints with a deceptively broad brush in describing the pre-PRRB "administrative structure for evaluating reimbursement claims" as "the intermediary system." In doing so he blurs the distinction between two separate intermediary functions. The first is the role of the intermediary as auditor of cost reports, which culminates in the issuance of the Notice of Program Reimbursement ("NPR"). The second is the role of the intermediary as hearing officer for disputes arising from the issuance of the NPR.

By confusing these two separate functions, the Secretary suggests by implication, but does not directly assert, that Congress intended the intermediary cost report audit process to embody an initial adjudication of an adversarial presentation of the provider's claim. Of course, that concept is critical to the Secretary's entire argument.

Not only does the legislative history referenced by the Secretary *not* support such a proposition, but that proposition runs afoul of the Secretary's own regulations. To analyze this, it is first necessary to look at what processes were in place at the time legislation for the PRRB was enacted.

At the time of the PRRB enabling legislation in 1972, as at the present time, intermediaries were required by their contracts with the Secretary to apply the Secretary's regulations, manual instructions and policies in auditing cost reports. They had no authority to pay a cost not authorized by such regulations or instructions when they issued an NPR.

At the same time, there existed as a separate function an informal intermediary hearing process which was established by contract between the Secretary and the intermediary.[3] This disputes resolution process occurred after the

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[3] Agreement between Secretary of Health, Education and Welfare and Blue Cross Association, No. SSA-70-0001-1, art. II, ¶ K (June 29, 1970) required the intermediary to

> establish and maintain such procedures as the Secretary may approve for considering and resolving any difference which may

issuance of the NPR and concerned only those issues which did not involve a challenge to the Secretary's policies or regulations, for there was nothing in the contract that permitted the intermediary hearing officer or appeals committee to override the intermediary's contractual obligation to implement the Secretary's regulations and manual instructions.

On May 27, 1972, the Secretary promulgated regulations specifically acknowledging that all intermediaries were required under their intermediary contracts to establish hearing procedures and requiring such procedures to conform to the new regulations. (37 Fed. Reg. 10724, May 27, 1972; 20 C.F.R. § 405.490 (1973)). Under these formalized procedures there was again no ability to challenge the Secretary's policies or regulation.[4]

Under neither these regulations nor the intermediary contract was there *any* resort to the agency if the provider was dissatisfied with the result of the hearing or wished to challenge policies or regulations. Thus, at the time of enactment of the PRRB enabling legislation, a provider could not address a challenge to either regulations or manual instructions to the intermediary because in both its audit and hearing capacities, the intermediary was bound

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arise when payment to an eligible individual or provider of services on behalf of an individual for services furnished to him has been denied or when the amount of such payment is in controversy and a procedure for considering and resolving any dispute arising between a provider of services and a Plan.

[4] 20 CFR. § 405.499b (1973) provided:

> The hearing officer(s) in exercising their authority must comply with all the provisions of title XVIII of the Act and regulations issued thereunder as well as with general instructions issued by the Social Security Administration [i.e., the various health insurance manual instructions] in accordance with the Secretary's agreement with the intermediary.

by those same regulations and instructions and there was no recourse to raise such issues with the agency. Of course, as indicated in the Hospitals' prior brief, any provider effort to gain access to judicial redress of reimbursement grievances at the time was vigorously and successfully contested by the Secretary.

Once the PRRB was created, disputes over the total amount of reimbursement involving $10,000 or more were filed with the PRRB, while disputes involving at least $1,000 but less than $10,000 were still filed with the intermediary as hearing officer. 42 C.F.R. §§ 405.1809, 405.1839 (1975). When the Secretary issued regulations implementing the PRRB enabling legislation on September 26, 1974 (39 Fed. Reg. 34515), he made one very significant change. While the intermediary hearing regulations still bound the intermediary by all regulations, manual provisions and rulings, 42 C.F.R. § 405.1829(a) (1975), the new PRRB regulations did *not* bind the Board by the manual instructions, the interpretative rules issued for intermediaries and providers.[5] This was the first time an administrative vehicle existed for challenging the Secretary's policies.

Three things emerge from this administrative history. First, the PRRB is a parallel dispute resolution process to the intermediary hearing officer process, not an appellate process which hears appeals from the intermediary hearing officer decision. The Secretary had an intermediary

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[5] 42 C.F.R. § 405.1867 (1975) provided:

> In exercising its authority to conduct the hearings described herein, the Board must comply with all the provisions of title XVIII of the Act and regulations issued thereunder, as well as rulings issued under the authority of the Commissioner of Social Security. . . . The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by the Bureau of Health Insurance.

dispute process in place at the time of the 1972 enactment and thus clearly knew the difference between a dispute process (the intermediary as hearing officer) and the cost report process (the intermediary as auditor).

Prior to the creation of the PRRB, disputes about the amount of reimbursement contained in the NPR went to the intermediary hearing officer. Following the creation of the PRRB, some disputes still went to the intermediary hearing officer while others went to the PRRB, depending on the amount in controversy. In *neither* situation was the intermediary, as auditor of the cost report and issuer of the NPR, considered part of the disputes resolution process. For the Secretary to imply now that the cost report audit process itself was some form of parallel disputes process that required exhaustion before a requlation could be challenged, or that Congress intended to preserve such a mechanism, is not an argument well taken.

Second, prior to the PRRB enabling legislation, there was no process by which a provider could challenge a regulation or manual instruction. Accordingly, it is misleading for the Secretary to suggest that, prior to the creation of the PRRB, providers knew that they had to raise claims contrary to regulations with the intermediary. Providers would not have bothered to claim costs in excess of those allowed under regulations from the intermediary because there was no appeals mechanism by which those costs could be reimbursed. Thus it is not reasonable to argue that the providers knew that they had to claim from the intermediary costs in excess of those allowed under regulations in order to preserve their appeal right to challenge regulations.

Third, by the Secretary's own regulations, the PRRB was not bound by manual provisions, thus allowing providers to challenge certain agency policy. This ability did not exist before. Moreover, although the Secretary by regulation denied the PRRB the right to referee challenges

to his regulations, that right was now for the first time clearly available through the administrative process, in that the statute permitted judicial review following a PRRB decision. 42 U.S.C. § 1395oo(f)(1) (1982). *See, e.g.*, PRRB Dec. No. 79-D91, *reprinted in* Medicare & Medicaid Guide (CCH) ¶ 30,374 (December 1979) (challenging 42 C.F.R. § 405.310(j) (1983)), ultimately decided by the Eleventh Circuit in *Memorial Hospital v. Heckler,* 706 F.2d 1130 (11th Cir. 1983), *cert. denied,* 465 U.S. 1023 (1984).[6]

In short, the Secretary misstates the legislative history when he claims that the PRRB enabling legislation is merely an overlay "atop the existing administrative structure to serve as an appellate body to referee disputes between providers and their intermediaries." Resp. Br. at 24. As is clear from the Secretary's own regulations, the PRRB was empowered to go far beyond the then-existing intermediary disputes process and to referee disputes with the Secretary over policy issuance and manual provisions. Once it is accepted that the PRRB can resolve disputes over the Secretary's policy and can certify disputes with the Secretary over regulations for expedited judicial review, then the Secretary's claim that such a dispute cannot be heard unless first raised with the intermediary in the cost report audit process gains the appearance of a bootstrap for a hardline position of denying providers access to administrative and judicial review.

C. The PRRB Acts As A Trial Forum, Not An Appellate Court

The Secretary's characterization of the Board as an appellate body totally disregards the provision of the statute which expressly gives the Board the trial court functions of

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[6] The 1980 Amendments providing expedited judicial review for challenges to regulations or other laws by which the PRRB was bound did not grant a right to challenge regulations but merely provided for expedited processing of such challenges.

hearing evidence, including evidence on matters not considered by the intermediary during the audit of the cost report. 42 U.S.C. § 1395oo(d). The intermediary participates as an adversary to the provider at the PRRB hearing, and presents its evidence in support of its position. The intermediary thus has a full opportunity to examine the provider's position and present its own case.

The Secretary's own regulations confirm the trial-like nature of the Board hearings. *See* 42 C.F.R. §§ 405.1853 (1975) (Prehearing discovery and other proceedings prior to the Board hearing);[7] 405.1855 (1975) (Evidence at Board hearing); 405.1857 (1975) (Subpoenas). Section 405.1859 (1975), entitled "Witnesses", states in part: "The Board may examine the witnesses and shall allow the parties or their representatives to do so." For the Secretary to argue that the Board only has a limited trial function ignores these fundamentals of his own Board proceedings.

The Secretary also states that "the Board was not to conduct a de novo review of all of the prior determinations." Resp. Br. at n. 16. Such assertions do not advance his position. The Hospitals' appeal to the PRRB specified that they were contesting the required application by the intermediary of the Malpractice Rule. The PRRB was thus not asked to conduct a de novo review of all prior intermediary determinations, but only the determination of the total amount of reimbursement due (as required by section 1395oo(a)) and in particular the intermediary's application of the Malpractice Rule which it was bound to apply in reaching that determination.

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[7] Since the intermediary can obtain discovery from the provider, the intermediary is in no way hampered in its participation at the Board hearing, contrary to the Secretary's argument, Resp. Br. at n.18.

III. THE SECRETARY'S INTERPRETATION IS NOT SUPPORTED BY THE STATUTE

Having demonstrated that the Secretary's fundamental premise is unsound, the Hospitals turn to other arguments raised by the Secretary. The Secretary's basic argument is that for purposes of the jurisdictional requirement of section 1395oo(a), "[a] provider can be 'dissatisfied' with the intermediary's determination only when the intermediary's reimbursement award falls short of the amount of reimbursement that the provider sought before the intermediary." Resp. Br. at 8.

The Secretary, however, contradicts his own assertion when he concedes that a provider may raise a claim before an intermediary simply by "noting its disagreement with the policy or regulation governing the reimbursement issue." Resp. Br. at n.8. If a provider completes its cost report in accordance with the regulation, and simply notes its disagreement with the regulation in a cover note, the intermediary's reimbursement award will be *precisely* the amount of reimbursement that the provider sought before the intermediary, just as in the instant case. If the Secretary deems a provider dissatisfied simply because it notes a disagreement with the regulation, he should also deemed the self-disallowing Hospitals dissatisfied on the facts of this case.

In addition, the Secretary's reading simply does not take into account the fact that the cost report is essentially a self-auditing system wherein the providers are expected to complete the forms in accordance with instructions and regulations issued by the Secretary and that the intermediary's job is simply to audit that cost report to determine that it has been completed correctly. Where the expectation is that regulations will be followed and the inclination is to follow regulations in completing such a

document, a reading that denies a provider the opportunity to present to the PRRB a challenge to regulations in completing the cost report falls far short of a reasonable interpretation under the circumstances—particularly when the PRRB has no authority to rule upon such a challenge. The Secretary's newly proposed reading would make more sense if there were no regulations and instructions governing costs and their treatment in the cost report. However, that is not the case before this Court.

The Secretary's concession that a cover note filed with the cost report suffices to preserve appeal rights also destroys his argument that petitioners' interpretation of the statute would make the amount in controversy requirement difficult to administer. The Secretary argues that when the "intermediary rejects a claim for reimbursement set forth in cost report, it is easy to establish the amount in controversy; the intermediary's determination need only be compared to the provider's initial claim." Resp. Br. at 14. But, of course, this comparison cannot be made when the provider simply notes a disagreement with a regulation or instruction relating to reimbursement. In addition, the amount in controversy does not have to be determined with precision, but only to satisfy the Board that the amount is at least $10,000. PRRB Hearing Manual § 1150.342, *reprinted in* Medicare and Medicaid Guide (CCH) ¶ 7514.25. Since this can be readily determined even when the disagreement is based on a cover note, the Secretary's contention has no merit.

As for the language in section 1395oo(f)(1), the Secretary's concession concerning the cover note also undermines his argument that judicial review depends on an "action" of the fiscal intermediary such as a rejection or nonacceptance of the provider's claim. Resp. Br. at 15.[8]

[8] The Hospitals' position is that the language in section 1395oo(f)(1), which refers to "judicial review of any action of the fiscal intermediary", means the action of the intermediary in granting the reimbursement claimed in accordance with the regulation.

When a provider simply notes its disagreement with a regulation and otherwise self-disallows a claim, the intermediary does not reject or nonaccept the provider's claim. Yet the Secretary concedes that under these circumstances the Board has jurisdiction and judicial review is appropriate.

IV. NO PRACTICAL CONSIDERATIONS SUPPORT THE SECRETARY'S INTERPRETATION.

The Secretary supports his self-disallowance policy by invoking the interests of administrative efficiency. However, in cases like this one involving a challenge to a regulation, efficiency interests are totally on the side of the Hospitals. Had the Hospitals ignored the 1979 Malpractice Rule in filling out their cost report, the intermediary would have been required to rework the entire submission to conform it to the regulation and to make an audit adjustment. Yet the only "analysis" contained in the adjustment would have been a citation to the 1979 Malpractice Rule. Thus significant additional work would be necessitated, but the result would be no different than if the Hospitals self-disallowed: reimbursement for malpractice insurance costs would be awarded only in the amount allowed under the 1979 Malpractice Rule. Such a useless and time-consuming procedure hardly serves interests of administrative efficiency. ,

Moreover, the Secretary's concern that a self-disallowance deprives the intermediary of an opportunity to examine background information is belied by the practice of the agency in finding jurisdiction where the provider attaches a cover note. If jurisdiction exists then, when an intermediary performs no analysis other than what it performs for a self-disallowing hospital, there is no practical reason why the PRRB should be deprived of jurisdiction over the Hospitals here.

Finally, the Secretary argues that the dispute must be raised in the cost report because the Board has only 30 days to rule on a request for expedited review, and the Board must make use of the intermediary's evaluation of the question. Resp. Br. at n. 20. The Secretary fails to point out that, by regulation, the provider must send a copy of the expedited review request and supporting documentation to the intermediary at the time it files the request. 42 C.F.R. § 405.1842(d)(1)(ii) (1983). The intermediary then may submit its comments on the request to the Board. 42 C.F.R. § 405.1842(e) (1983). If at any point the Board believes it needs additional information to rule on the request, it can (and routinely does) ask for additional information, which tolls the 30-day period for ruling on the request. 42 C.F.R. § 405.1842(d)(3) (1983). Thus there is ample opportunity for intermediary imput. But in cases where the only issue is the validity of a regulation, the intermediary's comments will have no effect and be of little value.[9]

V. THE SECRETARY DID NOT GIVE NOTICE THAT A PROVIDER FORFEITS APPEAL RIGHTS BY COMPLYING WITH REGULATIONS

First, even if this Court finds the Hospitals did have, or should have had, notice of the Secretary's self-disallowance policy, that policy is nonetheless unsupportable. In addition to all the reasons discussed above, such a

[9] The Secretary contends that intermediary consideration of claims it cannot grant is nonetheless useful because intermediaries have suggested changes in regulations based on their experience. Resp. Br. at 32. The Secretary apparently does not listen to such suggestions. Blue Cross Association and Blue Shield Association, the leading intermediary, filed comments severely critical of the proposed 1979 Malpractice Rule even before it had experience in implementing the Rule. Rulemaking Record, Vol. 5, p. 448. These comments were totally ignored by the Secretary.

policy takes advantage of the natural inclination to follow instructions in making difficult calculations, for no worksheets in the cost report told a hospital how to calculate its cost in violation of the regulations.

The Secretary's policy also turns on its head the Congressional mandate by forcing providers to choose their battles *before* they file their cost reports, rather than *after* they receive their NPRs as the clear language statute requires. Not only does it turn the cost reporting process into an unwarranted adversary process, it works against a natural disputes resolution incentive built into the administrative scheme by Congress. That is, if a provider is generally satisfied with the total amount of reimbursement received as indicated in the NPR, it will be less likely to challenge a regulation in an effort to obtain still more reimbursement. Requiring a challenge to be mounted at the time the cost report is filed has the effect of vesting the provider with a commitment to the pursuit of additional reimbursement. This ultimately inures to the detriment of the administration of the Medicare Program.

In any event, the Secretary does not have the power to construct such artificial and restrictive barriers to jurisdiction in view of the waiver of sovereign immunity granted by Congress. *See* Pet. Br. at 42-43. This lack of power is not remedied by prior notice that a loss of the right to be heard flows from failure to adhere to prehearing requirements not required by the statute.

The unsupportability of the policy aside, the Hospitals assert that notice of the self-disallowance policy was not given by the Secretary. Nowhere do the Secretary's manual provisions state that a provider can preserve its appeal rights simply by attaching a cover note to its cost report.

It is noteworthy that, in his argument concerning notice, Resp. Br. 38-39, the Secretary does not reference his earlier citation to the section of the Provider Reimburse-

ment Manual where this policy purportedly appears. Resp. Br. at 33 and n.22. The reason is obvious. While the current version of PRM § 115, published in September 1981 and effective for cost reports filed on or after July 1, 1981, Resp. Br. at 33, arguably articulates the Secretary's policy, the version of section 115 in effect at the time the Hospitals filed their cost reports in March 1981 contained only the same sort of language that was contained in Section 2425.1, which the Hospitals discussed at pages 44-46 of their Brief. This language states only that providers could include in their cost reports costs disallowed in prior years without fear of fraud investigation if they disclosed the issue. *See* Resp. Brief at 33 n.22.[10] Nothing in this 1980 language states that if a provider wishes to challenge a policy or regulation, that issue must be raised with the intermediary when the cost report is filed or else the provider forfeits its right to appeal to the PRRB.

Rather than cite to the relevant language of the Manual which does not support his position, the Secretary relies instead on the fact that other providers raised the malpractice issue with the intermediary and that prior decisions of the Board allegedly set forth the self-disallowance policy. However, even the two Hospitals here can be said to have raised the issue, in that they participated along with 6,000 other hospitals in an industry-wide suit filed directly in district court in 1979 to challenge the 1979 Malpractice Rule. *Hadley Memorial Hospital, Inc. v. Schweiker,* 689

[10] This is made clear by the next section of the 1980 version of section 115, which was not included in the Secretary's brief:

> 115 1A. The nonallowable cost items must be consistent with the item adjusted by the intermediary *from the prior cost report(s) and currently in dispute before the intermediary hearing officer or the Provider Reimbursement Board*; or the adjustment issue must be consistent with a decision(s) rendered by the intermediary hearing officer or the Provider Reimbursement Review Board.

F.2d 905, 906 (10th Cir. 1982).[11] This suit was filed in 1979, long before the issuance of the Hospitals' NPRs, and was hotly contested. It was not until the Tenth Circuit decided *Hadley* in 1982 that there was a clear directive that such challenges to a regulation had to be brought first to the PRRB. *Id.* at 910. With the Secretary and his agents thus put on notice through the *Hadley* lawsuit that the Hospitals challenged the regulation, there was no need to also apprise the intermediary by disputing the issue in the filing of the cost report. *See Tallahassee,* 815 F.2d at 1463 n.53.

As to the second point, most of the PRRB cases cited by the Secretary at page 34, note 23, were decided after the cost year here at issue (1980). Even those cases decided before then only demonstrate the confusion in the area and the need for a clear and unequivocal statement in regulations by the Secretary of his position, a statement which was never made.

As discussed at Pet. Br. at 38-39, the Board on several occasions accepted jurisdiction over self-disallowed costs. *See also Athens I,* 686 F.2d at 996-97.[12] The Secretary attempts to distinguish these by arguing that in these cases the cost report was otherwise properly before the Board. Resp. Br. at 35 n.24. In the absence of any manual provision or regulation explicitly setting forth the Secretary's policy, however, such a hypertechnical distinction would be lost on many hospitals. In light of the fact the Board accepted jurisdiction over self-disallowed cost in some cases, it is not reasonable to say the Secretary effectively gave notice of his self-disallowance policy.

[11] One of the plaintiffs in the suit was the Ohio Hospital Association, on behalf of all of its members including the two petitioner Hospitals.

[12] Often, however, when the Board accepts jurisdiction over self-disallowed costs, the jurisdictional issue is not discussed in the decisions in the same way court opinions do not discuss jurisdictional issues. This makes it difficult to document all the occasions when the Board did accept jurisdiction.

VI. THE PRRB DOES NOT HAVE DISCRETION TO REFUSE TO HEAR AN APPEAL CONCERNING A SELF-DISALLOWED COST

The Secretary concludes his discussion of the PRRB's jurisdiction by adopting the position taken by the First Circuit in *St. Luke's Hospital v. Secretary of Health and Human Services*, 810 F.2d 325 (1st Cir. 1987), i.e., that the PRRB has discretionary jurisdiction with regard to self-disallowed costs (Resp. Br. at 39-41). This position must be rejected out of hand, for *St. Luke's* is a case interpreting section 1395oo(d) and the Secretary has already conceded that subsection (a), not subsection (d), controls the Board's jurisdiction. Subsection (a) does not confer any discretionary authority on the Board.[13] If a provider meets the criteria set forth in subsection (a), as do the Hospitals here, the Board *must* take jurisdiction over the appeal.[14]

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[13] When subsection (a) states that a provider "may obtain a hearing," it clearly means that the *provider* has the discretion to decide whether to ask for a hearing, not that the PRRB can refuse to accept jurisdiction if the provider meets the statutory criteria.

[14] The Secretary's reliance on Thomas v. Arn, 474 U.S. 140 (1985), Resp. Br. at 40, is particularly misplaced. In that case the Court upheld the rule that a party must object to a magistrate's report before the District Court in order to obtain review of an issue in the Court of Appeals. This rule "prevents a litigant from sandbagging the District Judge by failing to object, then appealing". *Id.* at 147-148. It can hardly be said that the provider sandbags the intermediary by following a regulation that the intermediary is bound to enforce and has no authority to vary in any respect, and then raising an objection to that regulation in the forum provided by Congress to hear such appeals.

CONCLUSION

For the foregoing reasons, the decision of the court of appeals should be reversed, and the case should be remanded with instructions to pay the Hospitals their malpractice insurance costs in accordance with the pre-1979 utilization methodology, as were the other plaintiffs.

Respectfully submitted,

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